

School Year 2025-2026

Hemphill Independent School District P.O. Box 1950 Hemphill, Tx. 75948 409-787-3371 Fax 409-787-4137

Student Emergency Care and Health Form

_____, _____ / _____
Last Name First Middle Age Birthdate

Mailing Address City/Zip Code

Mother/Guardian: _____ Home # _____

Cell Phone: _____ Work Phone: _____

Father/Guardian: _____ Home # _____

Cell Phone: _____ Work Phone: _____

Student Live With _____ Relationship _____

Other people who are authorized to pick up or transport my child if I am unable to be located:

Name Phone/Relationship

Name Phone/Relationship

Name Phone/Relationship

Health Information

Does your child have any **SEVERE or LIFE-THREATENING** allergies? No Yes > Please List Below

Does your child need treatment for these allergies **while at school** - No Yes > See Nurse For Form

****PARENTS MUST SUPPLY ALL MEDICATIONS****

Complete the following by checking all that apply to your child:

_____ **ASTHMA- (IF YOU CHECK THIS, SEE SCHOOL NURSE)**

Currently Prescribed Medications or Treatments **needed at school for asthma**

Does student carry inhaler on self at school - NO YES > (SEE NURSE FOR FORM)

_____ **DIABETES - (SEE SCHOOL NURSE)**

_____ **SEIZURE DISORDER - (SEE SCHOOL NURSE)**

(GO TO PAGE 2)

____ OTHER HEALTH CONDITIONS - (PLEASE LIST CONDITIONS)

Is your child on any routine medications - NO YES > (SEE SCHOOL NURSE) PLEASE LIST

Will your child be taking any routine medication at school - NO YES > (SEE SCHOOL NURSE) PLEASE LIST

Does your child require special procedures while at school - NO YES > (SEE SCHOOL NURSE)

____ VISION CONDITIONS? CONTACTS GLASSES

____ HEARING CONDITIONS? If checked, does the student wear Hearing Aids? YES NO

Hemphill ISD **DOES NOT** provide over the counter medications such as Ibuprofen, Tylenol, creams, cough drops, etc. If you want your child to have medications at school, the parent must bring them to the nurse's clinic in the original, labeled container and completed permission forms. **ANY MEDICATIONS THAT EXPIRE WHILE IN THE POSSESSION OF THE SCHOOL CLINIC WILL BE DISCARDED.**

All/any of the above information may be provided to Hemphill ISD staff in order to keep each student's health and safety at top priority. This information will only be given to those teachers, coaches, and staff directly involved with the student. Staff members are informed that all student information is confidential.

By signing below, the parent agrees to the above information and also authorizes Hemphill ISD to use its judgment in securing the immediate care needed, including transportation in case of an emergency situation. Parent/Guardian accepts full responsibility for all charges incurred for these services.

Parent/Guardian_____ Date_____